STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295011	A. BUILDING _____ B. WING _____	11/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LYON MEDICAL CENTER	P.O. BOX 940 YERINGTON, NV 89447

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of an Annual Medicare Recertification survey conducted at your facility on November 1 through November 5, 2010. The census was 43 residents. The sample size was eleven, including one closed record. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the physician was notified of a resident's non-compliance with fluid restriction for 1 of 11 residents (#2).

Findings include:

Resident #2

Resident #2 was admitted to the facility on 4/30/10, with diagnoses that included on chronic kidney disease, hypertension, and diabetes mellitus. Resident #2 received dialysis three times weekly.

On the initial tour a staff nurse reported Resident #2 was on a 1500 cc (cubic centimeters) fluid restriction. The staff nurse reported the resident did not like to be reminded of her fluid restriction, but rarely went over the 1500 cc limit.

Review of Resident #2's record revealed an order written on 9/8/10, for a 1200 cc fluid restriction.

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F 157	Continued From page 2 Review of the resident's care plan conferences revealed the resident did not want to be reminded of her fluid and dietary restrictions. Review of the intake and output records revealed the resident consumed more than 1200 cc eleven times in a 24 hour period during the month of October. The three days a week the resident received dialysis, the intake and output records did not document any fluid intake during dialysis, or during the travel time, only that the resident was out of the facility. Review of the nurse's notes failed to reveal notification of Resident #2's physician of her non-compliance with the fluid restriction. On 11/3/10, a staff nurse was interviewed. She confirmed the physician had not been notified of Resident #2's non-compliance with the fluid restriction.	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to evaluate a resident for self-administration of medication for 1 of 11 residents (#2). Findings include: Resident #2 Resident #2 was admitted to the facility on	F 176		

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F 176	Continued From page 3 4/30/10, with diagnoses that included chronic kidney disease, hypertension, diabetes mellitus and coronary atherosclerosis. Resident #2 received dialysis three times weekly. Review of Resident #2's record revealed a nursing entry dated 10/8/10, "Also given Ativan 0.5 mg tab 1 for later in the day." Review of the physician orders revealed an order was written on 10/13/10 for "Ativan 0.5 mg, one by mouth every dialysis day. Resident may carry med and self-administer prn (as needed) for anxiety." Further review of the record failed to indicate the resident had been assessed for safe self-administration of the medication. On 11/3/10, the Director of Nurses was interviewed. She confirmed Resident #2 had not been assessed for safe administration of the medication.	F 176		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to make available, to utilize and to maintain hearing aids for 2 of 11 residents (#5 and #6), and to have a shelf at appropriate height for 1 of 11 residents (#12) to maintain independence in	F 246		

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performance of her activities of daily living.

Findings include:

Resident #5

Resident #5 was admitted to the facility on 2/1/08, with diagnosis that included dementia, dysthymic disorder, gout and hypertension.

The Minimum Data Set (MDS) identified as a quarterly assessment with a look back period of 5/2/10 recognized the resident as having minimal difficulty and having a hearing aid, present and used. A quarterly MDS completed in 10/2010, identified Resident #5 as having moderate difficulty with no hearing aid used.

Resident # 5's behaviors were reviewed by the Behavioral Committee monthly. Notes, dated 5/4/10, indicated that the resident had 4 incidents in the past week, including striking out at caregivers, refusing to move and being verbally abusive. The documentation further indicated that the resident's hearing aid had been missing for several days and that perhaps sensory deprivation was related to behaviors.

Notes included in the Care Plan for Self Care Deficit indicated that on 6/1/10, Resident #5's hearing aid was lost and that the family would not replace it. An additional note, dated 6/18/10, indicated that the hearing aid was found.

A physician's order was written on 7/3/10 directing nursing staff to remove the resident's hearing aid (right ear only) at night and to place it in the nursing cart, and to replace it in the morning.

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F 246	Continued From page 5 The Mood State/Depression/Psychological Wellbeing section of the Care Conference for 10/2010, documented that being hard of hearing (HOH) interfered with activities like visiting with others. Social Services entries for 4/30/10, indicated that the facility was not willing to replace the hearing aid if lost. Additional social services notes documented that the hearing aid lost on 6/1/10, was found in the nurses cart on 6/18/10. Resident #6 Resident #6 was admitted to the facility on 1/18/10, with diagnoses that included depression, a corneal injury, anemia, and dementia. A Minimum Data Set (MDS) identified as a quarterly and completed on 9/21/10, documented the resident as having minimal hearing difficulty with a hearing aid present and used. Notes from Social Services, dated 5/4/10, indicated that the resident had dropped and broken her hearing aid. It was mailed out for repairs and not received back until 5/17/10 (approximately 2 weeks). Notes indicated that the hearing aid was broken again 9/7/10, and received back on 9/28/10 (3 weeks). There was no evidence of a care plan related to the use, storage and maintenance of the hearing aid. Resident #6's hearing problem was mentioned in a self care deficient care plan. Resident #12	F 246		

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F 246	Continued From page 6 On 11/2/10, a group interview was conducted with seven residents. Resident #12 reported the shelf in her bathroom that held her personal care items was too high for her to reach while seated in her wheelchair. On 11/3/10, Resident #12's room and bathroom were observed. The shelf in the bathroom was located over the toilet and was approximately 60 inches from the ground. The resident was unable to reach her personal care items on the shelf.	F 246		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		

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Based on record interview and staff interview, the facility failed to develop comprehensive care plans for 5 of 11 residents (#5, #6, #7, #9, and #11).

Findings include:

Resident #5

Resident #5 was admitted to the facility on 2/1/08, with diagnosis that included dementia, dysthymic disorder, gout and hypertension.

The Minimum Data Set (MDS) identified as a quarterly assessment with a look back period of 5/2/10, recognized the resident as having minimal difficulty and having a hearing aid, present and used. A quarterly MDS completed in 10/2010, identified Resident #5 as having moderate difficulty with no hearing aid used.

Resident # 5's behaviors were reviewed by the Behavioral Committee monthly. Notes, dated 5/4/10, indicated that the resident had 4 incidents in the past week, including striking out at caregivers, refusing to move and being verbally abusive. The documentation further stated that the resident's hearing aid had been missing for several days and that perhaps sensory deprivation is related to behaviors.

Notes included in the Care Plan for Self Care Deficit indicated that on 6/1/10, Resident #5's hearing aid was lost and that the family would not replace it. An additional note, dated 6/18/10, indicated that the hearing aid was found.

A physician's order was written on 7/3/10, directing nursing staff to remove the resident's

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hearing aid (right only) at night and to place it in the nursing cart, and to replace it in the morning.

The Mood State/Depression/Psychological Wellbeing section of the Care Conference for 10/2010, documented that being hard of hearing (HOH) interfered with activities like visiting with others.

Social Services entries for 4/30/10, indicated that the facility was not willing to replace the hearing aid if lost. Additional social services notes documented that the hearing aid lost on 6/1/10, was found in the nurses cart on 6/18/10.

There was no evidence of a care plan dedicated to the use, security, and maintenance of the resident's hearing aide with specific approaches. Problems related to the hearing aid are addressed as comments in the Self Care Deficit care plan.

Resident #6

Resident #6 was admitted to the facility on 1/18/10, with diagnoses that included depression, a corneal injury, anemia, and dementia.

1) A Minimum Data Set (MDS) identified as a quarterly and completed on 9/21/10, documented the resident as having minimal hearing difficulty with a hearing aid present and used.

Notes from Social Services, dated 5/4/10, indicated that resident had dropped and broken her hearing aid. It was mailed out for repairs and not received back until 5/17/10 (approximately 2 weeks). Notes indicated that the hearing aid was broken again 9/7/10, and received back on

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F 279	Continued From page 9 9/28/10 (3 weeks). 2) An entry was made 1/19/10, under the care plan entitled, "Risk for Imbalanced Nutrition." The entry indicated that Resident #6 was now on a 1500 cc fluid restriction. The fluid restriction was due to a sodium depletion problem. There was no evidence of a care plan detailing how the fluid restriction was to be enforced. In an interview with the MDS staff on 11/2/10, it was relayed that the restriction was controlled by the CNA staff passing on from shift to shift how much fluid that Resident #6 had consumed. It was acknowledged that there was no written plan with approaches to attain the goal of consuming only 1500 ccs of fluids. Resident #7 Resident #7 was admitted to the facility on 10/6/10, with diagnoses of Diabetes Type 2, Bipolar, hypertension, and anxiety. 1) A preprinted care plan for Bowel and Bladder was in the resident's record. There were no indications as to which preprinted approaches were specific for this resident, nor were any of specific descriptor for this resident circled to indicate this resident's history and/or status. The MDS staff agreed that the care plan had not be completed. 2) The Care Area Assessment (CAA) Summary for Resident #7 indicated that a care plan addressing "pressure ulcer" had been developed. However, no care plan for pressure ulcers could be located in the resident record. MDS staff concurred that no care plan for pressure ulcers had been developed.	F 279		

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3) The resident summary, dated 10/13/10, identified Resident #7 as having been admitted to the facility on antibiotic therapy for a urinary tract infection. There was no evidence of a care plan for the treatment/prevention/monitoring of urinary tract infections.

Resident #9

Resident #9 was admitted on 8/04/04, with diagnoses of depression, Type II Diabetes, and hypertension.

Resident #9 required varying doses of sliding scale insulin coverage for her blood sugars. She also was diagnosed with peripheral neuropathy with foot pain and decreased sensation. The Minimum Data Set (MDS), identified as an annual assessment completed on 8/19/10, documented Resident #9 as having one or more foot problems; that is, corns, callus, bunions, etc. There was no evidence of a care plan identifying the need for regularly scheduled foot evaluations for diabetic patients and the recording of such examinations.

Existing care plans identified problems and established goals, but on many occasions neglected to define specific approaches needed to attain the stated goals.

Resident #11

Resident #11 was admitted to the facility on 6/6/01, with diagnoses that included depression, tremors, osteoarthosis, and peripheral neuropathy.

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F 279	Continued From page 11 Review of Resident #11's minimum data sets with reference dates of 8/29/10, and 10/10/10, revealed the resident was rated as moderately impaired for hearing and wore a hearing aid. Review of Resident #11's record failed to reveal a care plan for use or care of the hearing aids.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure there was ongoing communication between the outpatient dialysis center and the facility to maintain the highest practicable well-being for 1 of 11 residents (#2). Findings include: Resident #2 Resident #2 was admitted to the facility on 4/30/10, with diagnoses that included chronic kidney disease, hypertension, diabetes mellitus and coronary atherosclerosis. Resident #2 received dialysis three times weekly. Review of Resident #2's record failed to reveal exchange of information with the dialysis center	F 309		

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F 309	Continued From page 12 regarding social services, nursing or dietary communications. Review of the resident's nurse's notes revealed some entries documented the resident was out of the facility for dialysis. Resident #2's record was reviewed on 11/2/10. The latest nursing note was dated 10/23/10. The resident had been out of the facility for dialysis four times since 10/23/10, with no documentation of the dialysis.	F 309		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was served under sanitary conditions. Findings include: On 11/1/10, tray line preparation was observed. The cook was observed wearing latex gloves and was handling the dishes, serving utensils, and dish covers to prepare the trays. While preparing the pureed food, the cook was observed to pat the pureed meat down and arrange it on the plate, using her gloved hand.	F 371		

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F 371	Continued From page 13 On 11/1/10, the cook was interviewed. The cook reported she was trying to make the food presentable. She confirmed she should not have touched the food with the gloved hand that was handling the dishes and utensils.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LYON MEDICAL CENTER	P.O. BOX 940 YERINGTON, NV 89447

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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This REQUIREMENT is not met as evidenced by:
Based on observation, the facility failed to store over-the-counter medications properly.

Findings include:

Observation of the medication room at 11:30 AM on 11/2/10, revealed that the following over-the-counter (OTC) medications had been partially used and then returned to stock:

Vitamin C, 500 mg (open date of 6/1/10
Slow Fe 400 IU (open date 3/1/10)
Generic Stool softener
Dulcolax tablets
Generic allergy medication

Nursing staff concurred that the various OTC medications had been partially used and returned to the general stock.